Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Informed Consent

1 Did participant present for baseline visit?

☐ 0 No → **If No: Specify reason** *(check only one)*:
- ☐ 1 Failed an eligibility criterion *(participant no longer meets criteria)*
- ☐ 2 Lost interest in the study
- ☐ 3 Will take too much time
- ☐ 4 Scheduling conflicts with work or school
- ☐ 5 Doesn't like the study's procedures
- ☐ 6 Doesn't want to be involved in a research study
- ☐ 7 Unwilling to be randomized
- ☐ 8 Lives too far away/transportation problems
- ☐ 9 Needs help with child care *(unanticipated child care needs)*
- ☐ 10 Refused with no explanation
- ☐ 11 Unable to contact
- ☐ 98 Other *(specify)*: _____

☐ 1 Yes

2 Date and time study baseline informed consent signed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Informed Consent Detail

Tissue consent:

Sample type	Check only one		
	Participant consent given for future studies by Calerie and external investigators	**Participant consent given for future studies by Calerie**	**Participant consent not given**
1 Blood archive	☐ 1	☐ 2	☐ 3
2 Urine archive	☐ 1	☐ 2	☐ 3
3 Muscle biopsy archive	☐ 1	☐ 2	☐ 3
4 Fat biopsy archive	☐ 1	☐ 2	☐ 3

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Clinic Weight

Weight date and time: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59) **Staff initials:** ___ ___ ___ (first middle last)

OR Not done → Specify reason *(use Codelist below)*: _____

Clinic weight *(if the first two measurements are more than 0.1 kg apart, measure weight a third time)*:

Weight 1: ___ ___ ___ . ___ kg

Weight 2: ___ ___ ___ . ___ kg

Weight 3: ___ ___ ___ . ___ kg

Weight of gown: ___ ___ ___ . ___ kg

Vital Signs

Assessment date and time: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)

If waist measurement not done → Specify reason *(use codelist below)*: _____

1 **Natural waist measurement** **Staff initials:** ___ ___ ___ (first middle last)
(if the first two measurements are more than 1.0 cm apart, measure natural waist circumference a third time):

Natural waist measurement 1: ___ ___ ___ . ___ cm

Natural waist measurement 2: ___ ___ ___ . ___ cm

Natural waist measurement 3: ___ ___ ___ . ___ cm

2 **Umbilical point waist measurement** *(if the first two measurements are more than 1.0 cm apart, measure umbilical point waist circumference a third time)*:

Umbilical point waist measurement 1: ___ ___ ___ . ___ cm

Umbilical point waist measurement 2: ___ ___ ___ . ___ cm

Umbilical point waist measurement 3: ___ ___ ___ . ___ cm

3 **Pulse:** ___ ___ ___ bpm **OR** **Not done → Specify reason** *(use codelist below)*: _____ **Staff initials:** ___ ___ ___ (first middle last)

4 **Temperature:** ___ ___ ___ . ___ °C **OR** **Not done → Specify reason** *(use codelist below)*: _____ **Staff initials:** ___ ___ ___ (first middle last)

5 **Respirations:** ___ ___ per minute **OR** **Not done → Specify reason** *(use codelist below)*: _____ **Staff initials:** ___ ___ ___ (first middle last)

6 **Blood pressure** *(check only one)*: ☐1 Left arm ☐2 Right arm **Staff initials:** ___ ___ ___ (first middle last)

6a **Blood pressure 1:** ___ ___ ___ / ___ ___ ___ mm Hg (systolic / diastolic) **Time:** ___ ___ : ___ ___ (00:00 to 23:59) **OR Not done → Specify reason** *(use codelist below)*: _____

6b **Blood pressure 2:** ___ ___ ___ / ___ ___ ___ mm Hg (systolic / diastolic) **Time:** ___ ___ : ___ ___ (00:00 to 23:59)

6c **Blood pressure 3:** ___ ___ ___ / ___ ___ ___ mm Hg (systolic / diastolic) **Time:** ___ ___ : ___ ___ (00:00 to 23:59)

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

12-Lead ECG

Date and Time	Findings	Staff Initials
___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59) **OR Not done → Specify reason** (see codelist below): _____	**Is ECG** *(check only one)*: ☐ 1 Normal ☐ 2 Abnormal, not clinically significant *(specify)*: _____ ☐ 3 Abnormal, clinically significant *(specify)*: _____	___ ___ ___ (first middle last)

Safety Labs

Date and time of last meal: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)

Date and time of sample collection: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)

Sample	Sample Complete?	If Not Done, Reason *(Use codelist below)*	Staff Initials
Blood	☐ 0 No ☐ 1 Yes	_____	___ ___ ___ (first middle last)
Urine	☐ 0 No ☐ 1 Yes	_____	___ ___ ___ (first middle last)

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)

Abbreviated Medical History

List any clinically significant changes occurring since Screening medical history was completed.

Body System	Assessments		
	No Change	Yes	If Yes, Specify Diagnosis
1 Head, Ears, Eyes, Nose, Throat	☐ 0	☐ 1 →	
2 Dermatologic	☐ 0	☐ 1 →	
3 Cardiovascular	☐ 0	☐ 1 →	
4 Respiratory	☐ 0	☐ 1 →	
5 Gastrointestinal	☐ 0	☐ 1 →	
6 Endocrine/Metabolic	☐ 0	☐ 1 →	
7 Genitourinary	☐ 0	☐ 1 →	
8 Neurological	☐ 0	☐ 1 →	
9 Blood/Lymphatic	☐ 0	☐ 1 →	
10 Musculoskeletal	☐ 0	☐ 1 →	
11 Hepatic	☐ 0	☐ 1 →	
12 Drug Allergies	☐ 0	☐ 1 →	
13 Other Allergies	☐ 0	☐ 1 →	
14 Psychological/Psychiatric	☐ 0	☐ 1 →	
15 Other	☐ 0	☐ 1 →	

Physician's Signature

Signature: _____ Date: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Physical Examination

Date of examination: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)

Staff initials: ___ ___ ___ (first middle last)

OR Not done → Specify reason *(use codelist below)*: _____

Body System	Assessments			If Abnormal or Not Done: Explain
	Normal	Abnormal	Not Done	
1 General appearance:	☐ 1	☐ 0 →	☐ 97 →	
2 Head, Ears, Eyes, Nose, Throat:	☐ 1	☐ 0 →	☐ 97 →	
3 Neck:	☐ 1	☐ 0 →	☐ 97 →	
4 Heart:	☐ 1	☐ 0 →	☐ 97 →	
5 Lungs:	☐ 1	☐ 0 →	☐ 97 →	
6 Abdomen:	☐ 1	☐ 0 →	☐ 97 →	
7 Lymph nodes:	☐ 1	☐ 0 →	☐ 97 →	
8 Extremities/Skin:	☐ 1	☐ 0 →	☐ 97 →	
9 Neurological:	☐ 1	☐ 0 →	☐ 97 →	
10 Musculoskeletal:	☐ 1	☐ 0 →	☐ 97 →	
	Normal	**Abnormal**	**Not Done ***	
11 Genitourinary:	☐ 1	☐ 0 →	☐ 97 →	
12 Breast:	☐ 1	☐ 0 →	☐ 97 →	

Physician's Signature

Investigator: _____ (signature) Date: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)

* *Not done at this examination* **OR** *Referred participant to primary care physician for exam.*

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Clinic Weight

Weight date and time: ___ ___ /___ ___ ___ /___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59) **Staff initials:** ___ ___ ___ (first middle last)

OR Not done → Specify reason *(use codelist below):* ___

Clinic weight *(if the two measurements are more than 0.1 kg apart, measure weight a third time)*:

Weight 1: ___ ___ ___ . ___ kg

Weight 2: ___ ___ ___ . ___ kg

Weight 3: ___ ___ ___ . ___ kg

Weight of gown: ___ ___ ___ . ___ kg

Pregnancy Test

Complete only for females.

Does participant have reproductive potential?

☐ 0 No

☐ 1 Yes → **If Yes: Date urine pregnancy test performed:** ___ ___ /___ ___ ___ /___ ___ ___ ___ (day / month / year)

Results: ☐ 1 Negative
☐ 2 Positive

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Doubly Labeled Water (DLW)

1 Date and time of DLW dosing: ___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59) Staff initials: ___ ___ ___ (first middle last)

OR Not done → Specify reason *(use codelist below)*: ___

2 DLW dose mixture ID and bottle number: ___ ___ – ___ ___ ___ ___ – ___ ___ ___ – CA

3 Exact weight of DLW mixture: ___ ___ ___ . ___ ___ grams

4 Urine samples:

Collection	Sample	Date and Time Collected
Pre dosing *(PD)*	PDa	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
	PDb	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
Day 0 (Visit 2)	D0a	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
	D0b	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
Day 7 (Visit 3)	D7a	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
	D7b	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
Day 14 (Visit 4)	D14a	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)
	D14b	___ ___/___ ___ ___/___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59)

5 Affix CRF page label(s) corresponding to this urine sample set:

Affix Label Here

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

DXA Scan

1 Has the participant taken a calcium supplement today?
☐ 0 No ☐ 1 Yes → **If Yes: Proceed with scan and document in the Subject Scan Log to inform the QA Center.**

2 Were any studies involving barium or radioisotopes performed within 4 weeks prior to the scheduled DXA exam?
☐ 0 No ☐ 1 Yes

DXA Scan		**DXA Rescan** OR ☐ 96 NA
Date of scan: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)		Date of rescan: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)
Area Scanned Check all that apply	**If Not Done, Reason** *(Use codelist below)*	**Area Scanned Check all that apply**
☐ Whole body	_____	☐ Whole body
☐ Forearm	_____	☐ Forearm
☐ Spine	_____	☐ Spine
☐ Hip	_____	☐ Hip

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Profile of Mood States

Instructions: Please describe **how you feel right now** by checking one box for each of the words listed below.

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
1 Friendly	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 Tense	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3 Angry	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4 Worn out	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 Unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 Clear-headed	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 Lively	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 Confused	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 Sorry for things done	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Shaky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11 Listless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12 Peeved	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13 Considerate	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14 Sad	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15 Active	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16 On edge	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17 Grouchy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18 Blue	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19 Energetic	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20 Panicky	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
21 Hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
22 Relaxed	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
23 Unworthy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
24 Spiteful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
25 Sympathetic	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
26 Uneasy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
27 Restless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
28 Unable to concentrate	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
29 Fatigued	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
30 Helpful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
31 Annoyed	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
32 Discouraged	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
33 Resentful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
34 Nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
35 Lonely	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
36 Miserable	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
37 Muddled	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
38 Cheerful	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
39 Bitter	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
40 Exhausted	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
41 Anxious	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
42 Ready to fight	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
43 Good-natured	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Profile of Mood States (continued)

Feeling	Not At All	A Little	Moderately	Quite A Bit	Extremely
44 Gloomy	☐0	☐1	☐2	☐3	☐4
45 Desperate	☐0	☐1	☐2	☐3	☐4
46 Sluggish	☐0	☐1	☐2	☐3	☐4
47 Rebellious	☐0	☐1	☐2	☐3	☐4
48 Helpless	☐0	☐1	☐2	☐3	☐4
49 Weary	☐0	☐1	☐2	☐3	☐4
50 Bewildered	☐0	☐1	☐2	☐3	☐4
51 Alert	☐0	☐1	☐2	☐3	☐4
52 Deceived	☐0	☐1	☐2	☐3	☐4
53 Furious	☐0	☐1	☐2	☐3	☐4
54 Efficient	☐0	☐1	☐2	☐3	☐4
55 Trusting	☐0	☐1	☐2	☐3	☐4
56 Full of pep	☐0	☐1	☐2	☐3	☐4
57 Bad-tempered	☐0	☐1	☐2	☐3	☐4
58 Worthless	☐0	☐1	☐2	☐3	☐4
59 Forgetful	☐0	☐1	☐2	☐3	☐4
60 Carefree	☐0	☐1	☐2	☐3	☐4
61 Terrified	☐0	☐1	☐2	☐3	☐4
62 Guilty	☐0	☐1	☐2	☐3	☐4
63 Vigorous	☐0	☐1	☐2	☐3	☐4
64 Uncertain about things	☐0	☐1	☐2	☐3	☐4
65 Bushed	☐0	☐1	☐2	☐3	☐4

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Perceived Stress Scale (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate how often you felt or thought a certain way. Please check only one answer for each question.

	Never	Almost Never	Some-times	Fairly Often	Very Often
1 In the last month, how often have you felt that you were unable to control the important things in your life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 In the last month, how often have you felt confident about your ability to handle your personal problems?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3 In the last month, how often have you felt that things were going your way?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4 In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ /___ ___ ___ /___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Pittsburgh Sleep Quality Index (PSQI)

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

During the past month...

1 When have you usually gone to bed? ___ ___ : ___ ___ *00:00 to 23:59*

2 How long (in minutes) has it taken you to fall asleep each night? _____ minutes

3 When have you usually gotten up in the morning? ___ ___ : ___ ___ *00:00 to 23:59*

4 How many hours of actual sleep did you get at night?
(This may be different than the number of hours you spend in bed.) ___ . ___ hours

5 During the past month, how often have you had trouble sleeping because you... *(check only one answer per question)*	**Not during the past month**	**Less than once a week**	**Once or twice a week**	**3 or more times a week**
a Cannot get to sleep within 30 minutes	☐ 0	☐ 1	☐ 2	☐ 3
b Wake up in the middle of the night or early morning	☐ 0	☐ 1	☐ 2	☐ 3
c Have to get up to use the bathroom	☐ 0	☐ 1	☐ 2	☐ 3
d Cannot breathe comfortably	☐ 0	☐ 1	☐ 2	☐ 3
e Cough or snore loudly	☐ 0	☐ 1	☐ 2	☐ 3
f Feel too cold	☐ 0	☐ 1	☐ 2	☐ 3
g Feel too hot	☐ 0	☐ 1	☐ 2	☐ 3
h Have bad dreams	☐ 0	☐ 1	☐ 2	☐ 3
i Have pain	☐ 0	☐ 1	☐ 2	☐ 3
j Other reason(s), please describe, including how often you have had trouble sleeping because of this reason(s): _____	☐ 0	☐ 1	☐ 2	☐ 3
6 During the past month, how often have you taken medicine *(prescribed or "over the counter")* to help you sleep?	☐ 0	☐ 1	☐ 2	☐ 3

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Pittsburgh Sleep Quality Index (PSQI) (continued)

	Never	Once or twice	Once or twice each week	3 or more times each week
7 During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	☐ 0	☐ 1	☐ 2	☐ 3

	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
8 During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?	☐ 0	☐ 1	☐ 2	☐ 3

	Very good	Fairly good	Fairly bad	Very bad
9 During the past month, how would you rate your sleep quality overall?	☐ 0	☐ 1	☐ 2	☐ 3

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___/___/___ (day/month/year) OR Not done → Specify reason *(use codelist below)*: _____

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "O = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience**.

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.2 Erotic parts of a man's body *(e.g., face, shoulders, legs)*	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.3 Erotic or romantic situations	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.4 Caressing, touching, undressing, or foreplay	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.5 Sexual intercourse, oral sex, touching to orgasm	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 Feel sexually aroused while alone	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.2 Actively seek sexual satisfaction	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.3 Feel sexually aroused with a partner	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
	Never	Rarely	Sometimes	Usually	Always				
2.4 Have normal lubrication with masturbation	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4				
2.5 Have normal lubrication throughout sexual relations	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4				

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.2 Masturbation	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.3 Casual kissing and petting	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.4 Sexual foreplay	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.5 Sexual intercourse, oral sex, etc.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	☐0	☐1	☐2	☐3	☐4
4.2 The intensity of your orgasm	☐0	☐1	☐2	☐3	☐4
4.3 The ability to have multiple orgasms *(if typical for you)*	☐0	☐1	☐2	☐3	☐4
4.4 Feelings of closeness and togetherness with your partner	☐0	☐1	☐2	☐3	☐4
4.5 Your sense of control *(timing)* of your orgasm	☐0	☐1	☐2	☐3	☐4
4.6 Feeling a sense of relaxation and well-being after orgasm	☐0	☐1	☐2	☐3	☐4

Derogatis Interview for Sexual Function (DISF-SR) (F) Female Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your **ideal** frequency of sexual intercourse?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___/___/___ (day/month/year) OR Not done → Specify reason *(use codelist below)*: _____

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version

Instruction: Below you will find a brief set of questions about your sexual activities. The questions are divided into different sections that ask about different aspects of your sexual experiences. One section asks about **sexual fantasies** or daydreams, while another inquires about the kinds of **sexual experiences** that you have. You are also asked about the nature of your **sexual arousal** and the quality of your **orgasm**. There are also a few other questions about different areas of your sexual relationship.

On some questions you are asked to respond in terms of a frequency scale, that is, "how often" do you perform the sexual activities asked about in that section. Some frequency scales go from "O = not at all" to "8 = four or more times a day." Other frequency scales range from "0 = never" to "4 = always." In the case of other questions, you will be asked to respond in terms of a satisfaction scale. This type of scale tells how much you enjoyed, or were satisfied by the sexual activity being asked about. Some satisfaction scales range from "0 = could not be worse" to "8 = could not be better." Other satisfaction scales go from "0 = not at all satisfied," to "4 = extremely satisfied."

In every section of the inventory the scales required for that section are printed just above the questions so it will be easy to follow. Although it is brief, take your time with the inventory. **For each item, please check the scale number that best describes your personal experience**.

If you have any questions, please ask the person who gave you the inventory for help.

Section 1—Sexual Cognition/Fantasy

During the past 30 days or since the last time you filled out this inventory, how often have you had thoughts, dreams, or fantasies about:	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
1.1 A sexually attractive person	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.2 Erotic parts of a woman's body *(e.g., face, genitals, legs)*	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.3 Erotic or romantic situations	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.4 Caressing, touching, undressing, or foreplay	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
1.5 Sexual intercourse, oral sex, touching to orgasm	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 2—Sexual Arousal

During the past 30 days or since the last time you filled out this inventory, how often did you have the following experiences?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
2.1 A full erection upon awakening	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.2 A full erection during a sexual fantasy or daydream	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.3 A full erection while looking at a sexually arousing person, movie, or picture	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.4 A full erection during masturbation	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
2.5 A full erection throughout the phases of a normal sexual response cycle, that is from undressing and foreplay through intercourse and orgasm	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 3—Sexual Behavior/Experiences

During the past 30 days or since the last time you filled out the inventory, how often did you engage in the following sexual activities?	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
3.1 Reading or viewing romantic or erotic books or stories	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.2 Masturbation	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.3 Casual kissing and petting	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.4 Sexual foreplay	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
3.5 Sexual intercourse, oral sex, etc.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8

Section 4—Orgasm

During the past 30 days or since the last time you filled out this inventory, how <u>satisfied</u> have you been with the following?	Not at all	Slightly	Moderately	Highly	Extremely
4.1 Your ability to have an orgasm	☐0	☐1	☐2	☐3	☐4
4.2 The intensity of your orgasm	☐0	☐1	☐2	☐3	☐4
4.3 The length or duration of your orgasm	☐0	☐1	☐2	☐3	☐4
4.4 The amount of seminal liquid that you ejaculate	☐0	☐1	☐2	☐3	☐4
4.5 Your sense of control (timing) of your orgasm	☐0	☐1	☐2	☐3	☐4
4.6 Feeling a sense of relaxation and well-being after orgasm	☐0	☐1	☐2	☐3	☐4

Participant's Initials: ___ ___ ___ (first middle last)

Derogatis Interview for Sexual Function (DISF-SR) (M) Male Version (continued)

Section 5—Drive and Relationship

	Not at all	Less than 1 per month	1 or 2 per month	1 per week	2 or 3 per week	4 to 6 per week	1 per day	2 or 3 per day	4 or more per day
5.1 With the partner of your choice, what would be your ideal frequency of sexual intercourse?	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8
	Not at all	Slightly	Moderately	Highly	Extremely				
5.2 During this period, how interested have you been in sex?	☐0	☐1	☐2	☐3	☐4				
5.3 During this period, how satisfied have you been with your personal relationship with your sexual partner?	☐0	☐1	☐2	☐3	☐4				
	Could not be worse	Very poor	Poor	Somewhat inadequate	Adequate	Above average	Good	Very good	Could not be better
5.4 In general, what would represent the best description of the quality of your sexual functioning?	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Food Cravings Questionnaire—Trait

Please indicate the extent to which you agree with each statement below, in general, by checking the appropriate box.

	Never OR NA	Rarely	Some-times	Often	Usually	Always
1 Being with someone who is eating often makes me hungry.	☐1	☐2	☐3	☐4	☐5	☐6
2 When I crave something, I know I won't be able to stop eating once I start.	☐1	☐2	☐3	☐4	☐5	☐6
3 If I eat what I am craving, I often lose control and eat too much.	☐1	☐2	☐3	☐4	☐5	☐6
4 I hate it when I give in to cravings.	☐1	☐2	☐3	☐4	☐5	☐6
5 Food cravings invariably make me think of ways to get what I want to eat.	☐1	☐2	☐3	☐4	☐5	☐6
6 I feel like I have food on my mind all the time.	☐1	☐2	☐3	☐4	☐5	☐6
7 I often feel guilty for craving certain foods.	☐1	☐2	☐3	☐4	☐5	☐6
8 I find myself preoccupied with food.	☐1	☐2	☐3	☐4	☐5	☐6
9 I eat to feel better.	☐1	☐2	☐3	☐4	☐5	☐6
10 Sometimes, eating makes things seem just perfect.	☐1	☐2	☐3	☐4	☐5	☐6
11 Thinking about my favorite foods makes my mouth water.	☐1	☐2	☐3	☐4	☐5	☐6
12 I crave foods when my stomach is empty.	☐1	☐2	☐3	☐4	☐5	☐6
13 I feel as if my body asks for certain foods.	☐1	☐2	☐3	☐4	☐5	☐6
14 I get so hungry that my stomach seems like a bottomless pit.	☐1	☐2	☐3	☐4	☐5	☐6
15 Eating what I crave makes me feel better.	☐1	☐2	☐3	☐4	☐5	☐6
16 When I satisfy a craving, I feel less depressed.	☐1	☐2	☐3	☐4	☐5	☐6
17 When I eat what I am craving, I feel guilty about myself.	☐1	☐2	☐3	☐4	☐5	☐6
18 Whenever I have cravings, I find myself making plans to eat.	☐1	☐2	☐3	☐4	☐5	☐6
19 Eating calms me down.	☐1	☐2	☐3	☐4	☐5	☐6

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Food Cravings Questionnaire—Trait (continued)

	Never OR NA	Rarely	Some-times	Often	Usually	Always
20 I crave foods when I am bored, angry, or sad.	☐1	☐2	☐3	☐4	☐5	☐6
21 I feel less anxious after I eat.	☐1	☐2	☐3	☐4	☐5	☐6
22 If I get what I am craving, I cannot stop myself from eating it.	☐1	☐2	☐3	☐4	☐5	☐6
23 When I crave certain foods, I usually try to eat them as soon as I can.	☐1	☐2	☐3	☐4	☐5	☐6
24 When I eat what I crave, I feel great.	☐1	☐2	☐3	☐4	☐5	☐6
25 I have no will power to resist my food crave.	☐1	☐2	☐3	☐4	☐5	☐6
26 Once I start eating, I have trouble stopping.	☐1	☐2	☐3	☐4	☐5	☐6
27 I can't stop thinking about eating, no matter how hard I try.	☐1	☐2	☐3	☐4	☐5	☐6
28 I spend a lot of time thinking about whatever it is I will eat next.	☐1	☐2	☐3	☐4	☐5	☐6
29 If I give in to a food craving, all control is lost.	☐1	☐2	☐3	☐4	☐5	☐6
30 When I'm stressed out, I crave food.	☐1	☐2	☐3	☐4	☐5	☐6
31 I daydream about food.	☐1	☐2	☐3	☐4	☐5	☐6
32 Whenever I have a food craving, I keep on thinking about eating until I actually eat the food.	☐1	☐2	☐3	☐4	☐5	☐6
33 If I am craving something, thoughts of eating it consume me.	☐1	☐2	☐3	☐4	☐5	☐6
34 My emotions often make me want to eat.	☐1	☐2	☐3	☐4	☐5	☐6
35 Whenever I go to a buffet, I end up eating more than what I needed.	☐1	☐2	☐3	☐4	☐5	☐6
36 It is hard for me to resist the temptation to eat appetizing foods that are in my reach.	☐1	☐2	☐3	☐4	☐5	☐6
37 When I am with someone who is overeating, I usually overeat too.	☐1	☐2	☐3	☐4	☐5	☐6
38 When I eat food, I feel comforted.	☐1	☐2	☐3	☐4	☐5	☐6
39 I crave foods when I'm upset.	☐1	☐2	☐3	☐4	☐5	☐6

Participant's Initials: ___ ___ ___ (first middle last)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Food Cravings Questionnaire—State (FCQ–S)

Below is a list of comments made by people about their eating habits. Please check one answer for each comment that indicates how much you agree with the comment **right now, at this very moment.** Notice that some questions refer to foods in general while others refer to one or more specific foods. Please respond to each item as honestly as possible.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1 I have an intense desire to eat [one or more specific foods].	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2 I'm craving [one or more specific foods].	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3 I have an urge for [one or more specific foods]	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4 Eating [one or more specific foods] would make things seem just perfect.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5 If I were to eat what I am craving, I am sure my mood would improve.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6 Eating [one or more specific foods] would feel wonderful.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7 If I ate something, I wouldn't feel so sluggish and lethargic.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8 Satisfying my craving would make me feel less grouchy and irritable.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9 I would feel more alert if I could satisfy my craving.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10 If I had [one or more specific foods], I could not stop eating it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11 My desire to eat [one or more specific foods] seems overpowering.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12 I know I'm going to keep on thinking about [one or more specific foods] until I actually have it.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13 I am hungry.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14 If I ate right now, my stomach wouldn't feel as empty.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15 I feel weak because of not eating.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Food Craving Inventory (FCI–II)

For each of the foods listed below, please check the appropriate box.

Note: A craving is defined as an intense desire to consume a particular food or food type that is difficult to resist.

Over the past month, how often have you experienced a craving for...	Never	Rarely (once or twice)	Sometimes	Often	Always/Almost Every Day
1 Cake	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2 Pizza	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3 Fried chicken	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4 Gravy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5 Sandwich bread	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6 Sausage	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7 French fries	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8 Cinnamon rolls	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9 Rice	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10 Hot dog	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11 Hamburger	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12 Biscuits	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13 Ice cream	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14 Pasta	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15 Fried fish	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16 Cookies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17 Chocolate	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18 Pancakes or waffles	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
19 Corn bread	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20 Chips	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
21 Rolls	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
22 Cereal	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
23 Donuts	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
24 Candy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
25 Brownies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
26 Bacon	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
27 Steak	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
28 Baked potato	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Eating Inventory

1	When I smell a sizzling steak or see a juicy piece of meat, I find it very difficult to keep from eating, even if I have just finished a meal.	☐ 1 True	☐ 0 False
2	I usually eat too much at social occasions, like parties and picnics.	☐ 1 True	☐ 0 False
3	I am usually so hungry that I eat more than three times a day.	☐ 1 True	☐ 0 False
4	When I have eaten my quota of calories, I am usually good about not eating anymore.	☐ 1 True	☐ 0 False
5	Dieting is so hard for me because I just get too hungry.	☐ 1 True	☐ 0 False
6	I deliberately take small helpings as a means of controlling my weight.	☐ 1 True	☐ 0 False
7	Sometimes things just taste so good that I keep on eating even when I am no longer hungry.	☐ 1 True	☐ 0 False
8	Since I am often hungry, I sometimes wish that while I am eating, an expert would tell me that I have had enough or that I can have something more to eat.	☐ 1 True	☐ 0 False
9	When I feel anxious, I find myself eating.	☐ 1 True	☐ 0 False
10	Life is too short to worry about dieting.	☐ 1 True	☐ 0 False
11	Since my weight goes up and down, I have gone on reducing diets more than once.	☐ 1 True	☐ 0 False
12	I often feel so hungry that I just have to eat something.	☐ 1 True	☐ 0 False
13	When I am with someone who is overeating, I usually overeat too.	☐ 1 True	☐ 0 False
14	I have a pretty good idea of the number of calories in common food.	☐ 1 True	☐ 0 False
15	Sometimes when I start eating, I just can't seem to stop.	☐ 1 True	☐ 0 False
16	It is not difficult for me to leave something on my plate.	☐ 1 True	☐ 0 False
17	At certain times of the day, I get hungry because I have gotten used to eating then.	☐ 1 True	☐ 0 False
18	While on a diet, if I eat food that is not allowed, I consciously eat less for a period of time to make up for it.	☐ 1 True	☐ 0 False

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Eating Inventory (continued)

19	Being with someone who is eating often makes me hungry to eat also.	☐1 True	☐0 False
20	When I feel blue, I often overeat.	☐1 True	☐0 False
21	I enjoy eating too much to spoil it by counting calories or watching my weight.	☐1 True	☐0 False
22	When I see a real delicacy, I often get so hungry that I have to eat right away.	☐1 True	☐0 False
23	I often stop eating when I am not really full as a conscious means of limiting the amount I eat.	☐1 True	☐0 False
24	I get so hungry that my stomach often seems like a bottomless pit.	☐1 True	☐0 False
25	My weight has hardly changed at all in the last ten years.	☐1 True	☐0 False
26	I am always hungry so it is hard for me to stop eating before I finish the food on my plate.	☐1 True	☐0 False
27	When I feel lonely, I console myself by eating.	☐1 True	☐0 False
28	I consciously hold back at meals in order not to gain weight.	☐1 True	☐0 False
29	I sometimes get very hungry late in the evening or at night.	☐1 True	☐0 False
30	I eat anything I want, any time I want.	☐1 True	☐0 False
31	Without even thinking about it, I take a long time to eat.	☐1 True	☐0 False
32	I count calories as a conscious means of controlling my weight.	☐1 True	☐0 False
33	I do not eat some foods because they make me fat.	☐1 True	☐0 False
34	I am always hungry enough to eat at any time.	☐1 True	☐0 False
35	I pay a great deal of attention to changes in my figure.	☐1 True	☐0 False
36	While on a diet, if I eat a food that is not allowed, I often splurge and eat other high calorie foods.	☐1 True	☐0 False

Eating Inventory (continued)

Please check one answer that is most appropriate to you for each question below.

37	**How often are you dieting in a conscious effort to control your weight?**	☐1 Rarely ☐2 Sometimes ☐3 Usually ☐4 Always
38	**Would a weight fluctuation of 5 pounds affect the way you live your life?**	☐1 Rarely ☐2 Sometimes ☐3 Usually ☐4 Always
39	**How often do you feel hungry?**	☐1 Rarely ☐2 Sometimes ☐3 Usually ☐4 Always
40	**Do your feelings of guilt about overeating help you to control your food intake?**	☐1 Rarely ☐2 Sometimes ☐3 Usually ☐4 Always
41	**How difficult would it be for you to stop eating halfway through dinner and not eat for the next four hours?**	☐1 Easy ☐2 Slightly difficult ☐3 Moderately difficult ☐4 Very difficult
42	**How conscious are you of what you are eating?**	☐1 Not at all ☐2 Slightly ☐3 Moderately ☐4 Extremely
43	**How frequently do you avoid "stocking up" on tempting foods?**	☐1 Almost never ☐2 Seldom ☐3 Usually ☐4 Almost always
44	**How likely are you to shop for low calorie foods?**	☐1 Unlikely ☐2 Slightly likely ☐3 Moderately likely ☐4 Very likely
45	**Do you eat sensibly in front of others and splurge alone?**	☐1 Never ☐2 Rarely ☐3 Often ☐4 Always
46	**How likely are you to consciously eat slowly in order to cut down on how much you eat?**	☐1 Unlikely ☐2 Slightly likely ☐3 Moderately likely ☐4 Very likely
47	**How frequently do you skip dessert because you are no longer hungry?**	☐1 Almost never ☐2 Seldom ☐3 At least once a week ☐4 Almost every day
48	**How likely are you to consciously eat less than you want?**	☐1 Unlikely ☐2 Slightly likely ☐3 Moderately likely ☐4 Very likely
49	**Do you go on eating binges though you are not hungry?**	☐1 Never ☐2 Rarely ☐3 Sometimes ☐4 At least once a week
50	**To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."**	☐1 Not like me ☐2 Little like me ☐3 Pretty good description of me ☐4 Describes me perfectly
51	**On a scale of 0 to 5, where 0 means no restraint in eating (eating whatever you want, whenever you want it) and 5 means total restraint (constantly limiting food intake and never "giving in"), what number would you give yourself?**	☐0 Eat whatever you want, whenever you want it ☐1 Usually eat whatever you want, whenever you want it ☐2 Often eat whatever you want, whenever you want it ☐3 Often limit food intake, but often "give in" ☐4 Usually limit food intake, rarely "give in" ☐5 Constantly limiting food intake, never "giving in"

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ /___ ___ ___ /___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Weight Efficacy Lifestyle Questionnaire (WEL)

This form describes some typical eating situations. Everyone has situations which make it very hard for them to keep their weight down. The following are a number of situations relating to eating patterns and attitudes. This form will help you to identify the eating situations which you find the hardest to manage.

Read each situation listed below and decide how confident (or certain) you are that you will be able to resist eating in each of the difficult situations. In other words, pretend that you are in the eating situation right now. On a scale from 0 (not confident) to 9 (very confident), choose ONE number that reflects how confident you feel now about being able to **successfully resist** the desire to eat. Check this number for each item.

I am confident that:	**Not confident** at all that you can resist the desire to eat									**Very confident** that you can resist the desire to eat
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1 I can resist eating when I am anxious *(nervous)*.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
2 I can control my eating on the weekends.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
3 I can resist eating even when I have to say "no" to others.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
4 I can resist eating when I feel physically run down.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
5 I can resist eating when I am watching TV.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
6 I can resist eating when I am depressed *(or down)*.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
7 I can resist eating when there are many different kinds of food available.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
8 I can resist eating even when I feel it is impolite to refuse a second helping.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
9 I can resist eating even when I have a headache.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Weight Efficacy Lifestyle Questionnaire (WEL) (continued)

I am confident that:	**Not confident** at all that you can resist the desire to eat									**Very confident** that you can resist the desire to eat
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
10 I can resist eating when I am reading.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
11 I can resist eating when I am angry *(or irritable)*.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
12 I can resist eating even when I am at a party.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
13 I can resist eating even when others are pressuring me to eat.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
14 I can resist eating when I am in pain.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
15 I can resist eating just before going to bed.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
16 I can resist eating when I have experienced failure.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
17 I can resist eating when high-calorie foods are available.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
18 I can resist eating even when I think others will be upset if I don't eat.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
19 I can resist eating when I feel uncomfortable.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9
20 I can resist eating when I am happy.	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS)

Instructions: Using the scale shown, please rate the following items on a scale from 1 to 7. Please answer as truthfully as possible.

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
1 Fasting is a good way to lose weight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
2 My sleep isn't as good as it used to be.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
3 I avoid eating for as long as I can.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
4 Certain foods are "forbidden" for me to eat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
5 I can't keep certain foods in my house because I will binge on them.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
6 I can easily make myself vomit.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
7 I can feel that being fat is terrible.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
8 I avoid greasy foods.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
9 It's okay to binge and purge once in a while.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
10 I don't eat certain foods.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
11 I think I am a good person.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
12 My eating is normal.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
13 I can't seem to concentrate lately.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
14 I try to diet by fasting.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
15 I vomit to control my weight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
16 Lately nothing seems enjoyable anymore.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
17 Laxatives help keep you slim.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
18 I don't eat red meat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
19 I eat so rapidly I can't even taste my food.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
20 I do everything I can to avoid being overweight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
21 When I feel bloated, I must do something to rid myself of that feeling.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
22 I overeat too frequently.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
23 It's okay to be overweight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
24 Recently I have felt that I am a worthless person.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
25 I would be very upset if I gained 2 pounds.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
26 I crave sweets and carbohydrates.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
27 I lose control when I eat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
28 Being fat would be terrible.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
29 I have thought seriously about suicide lately.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
30 I don't have any energy anymore.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
31 I eat small portions to control my weight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
32 I eat 3 meals a day.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
33 Lately I have been easily irritated.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
34 Some foods should be totally avoided.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
35 I use laxatives to control my weight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
36 I am terrified by the thought of being overweight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
37 Purging is a good way to lose weight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
38 I avoid fatty foods.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Multiaxial Assessment of Eating Disorder Symptoms (MAEDS) (continued)

	Never	Very Rarely	Rarely	Some-times	Often	Very Often	Always
39 Recently I have felt pretty blue.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
40 I am obsessed with becoming overweight.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
41 I don't eat fried foods.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
42 I skip meals.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
43 Fat people are unhappy.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
44 People are too concerned with the way I eat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
45 I feel good when I skip meals.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
46 I avoid foods with sugar.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
47 I hate it when I feel fat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
48 I am too fat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
49 I eat until I am completely stuffed.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
50 I hate to eat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
51 I feel guilty about a lot of things these days.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
52 I'm very careful of what I eat.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
53 I can "hold off" and not eat even if I am hungry.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
54 I eat even when I am not hungry.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
55 Fat people are disgusting.	☐1	☐2	☐3	☐4	☐5	☐6	☐7
56 I wouldn't mind gaining a few pounds.	☐1	☐2	☐3	☐4	☐5	☐6	☐7

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Date completed: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) OR Not done → Specify reason *(use codelist below)*: _____

Body Shape Questionnaire (BSQ)

We would like to know how you have been feeling about your appearance over the **past four weeks**.
Please read each question and check the box for the appropriate choice. Please answer all the questions.

Over the Past Four Weeks...	Never	Rarely	Some-times	Often	Very Often	Always
1 Has feeling bored made you brood about your shape?	☐1	☐2	☐3	☐4	☐5	☐6
2 Have you been so worried about your shape that you have been feeling that you ought to diet?	☐1	☐2	☐3	☐4	☐5	☐6
3 Have you thought that your thighs, hips, or bottom are too large for the rest of you?	☐1	☐2	☐3	☐4	☐5	☐6
4 Have you been afraid that you might become fat *(or fatter)*?	☐1	☐2	☐3	☐4	☐5	☐6
5 Have you worried about your flesh not being firm enough?	☐1	☐2	☐3	☐4	☐5	☐6
6 Has feeling full *(e.g., after eating a large meal)* made you feel fat?	☐1	☐2	☐3	☐4	☐5	☐6
7 Have you felt so bad about your shape that you have cried?	☐1	☐2	☐3	☐4	☐5	☐6
8 Have you avoided running because your flesh might wobble?	☐1	☐2	☐3	☐4	☐5	☐6
9 Has being with thin women/men made you feel self-conscious about your shape?	☐1	☐2	☐3	☐4	☐5	☐6
10 Have you worried about your thighs spreading out when sitting down?	☐1	☐2	☐3	☐4	☐5	☐6
11 Has eating even a small amount of food made you feel fat?	☐1	☐2	☐3	☐4	☐5	☐6
12 Have you noticed the shape of other women/men and felt that your own shape compared unfavorably?	☐1	☐2	☐3	☐4	☐5	☐6
13 Has thinking about your shape interfered with your ability to concentrate *(e.g., while watching TV, reading, listening to conversations)*?	☐1	☐2	☐3	☐4	☐5	☐6
14 Has being naked, such as when taking a bath, made you feel fat?	☐1	☐2	☐3	☐4	☐5	☐6
15 Have you avoided wearing clothes which make you particularly aware of the shape of your body?	☐1	☐2	☐3	☐4	☐5	☐6
16 Have you imagined cutting off fleshy areas of your body?	☐1	☐2	☐3	☐4	☐5	☐6

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Participant's Initials: ___ ___ ___ (first middle last)

Body Shape Questionnaire (BSQ) (continued)

Over the Past Four Weeks...	Never	Rarely	Some-times	Often	Very Often	Always
17 Has eating sweets, cakes or other high calorie food made you feel fat?	☐1	☐2	☐3	☐4	☐5	☐6
18 Have you not gone out on social occasions *(e.g., parties)* because you have felt bad about your shape?	☐1	☐2	☐3	☐4	☐5	☐6
19 Have you felt excessively large and rounded?	☐1	☐2	☐3	☐4	☐5	☐6
20 Have you felt ashamed of your body?	☐1	☐2	☐3	☐4	☐5	☐6
21 Has worry about your shape made you diet?	☐1	☐2	☐3	☐4	☐5	☐6
22 Have you felt happiest about your shape when your stomach has been empty?	☐1	☐2	☐3	☐4	☐5	☐6
23 Have you thought that you are the shape you are because you lack self-control?	☐1	☐2	☐3	☐4	☐5	☐6
24 Have you worried about other people seeing rolls of flesh around your waist or stomach?	☐1	☐2	☐3	☐4	☐5	☐6
25 Have you felt that it is not fair that other women/men are thinner than you?	☐1	☐2	☐3	☐4	☐5	☐6
26 Have you vomited in order to feel thinner?	☐1	☐2	☐3	☐4	☐5	☐6
27 When in company, have you worried about taking up too much room *(e.g., sitting on a sofa or bus seat)*?	☐1	☐2	☐3	☐4	☐5	☐6
28 Have you worried about your flesh being dimply?	☐1	☐2	☐3	☐4	☐5	☐6
29 Has seeing your reflection *(e.g., in a mirror or shop window)* made you feel bad about your shape?	☐1	☐2	☐3	☐4	☐5	☐6
30 Have you pinched areas of your body to see how much fat is there?	☐1	☐2	☐3	☐4	☐5	☐6
31 Have you avoided situations where people could see your body *(e.g., communal changing rooms or swimming pools)*?	☐1	☐2	☐3	☐4	☐5	☐6
32 Have you taken laxatives in order to feel thinner?	☐1	☐2	☐3	☐4	☐5	☐6
33 Have you been particularly self-conscious about your shape when in the company of other people?	☐1	☐2	☐3	☐4	☐5	☐6
34 Has worry about your shape made you feel you ought to exercise?	☐1	☐2	☐3	☐4	☐5	☐6

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Clinic Weight

Weight date and time: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) ___ ___ : ___ ___ (00:00 to 23:59) **Staff initials:** ___ ___ ___ (first middle last)

OR Not done → Specify reason *(use codelist below)*: ___

Clinic weight *(if the two measurements are more than 0.1 kg apart, measure weight a third time)*:

Weight 1:	___ ___ ___ . ___ kg
Weight 2:	___ ___ ___ . ___ kg
Weight 3:	___ ___ ___ . ___ kg
Weight of gown:	___ ___ ___ . ___ kg

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Seven-Day Physical Activity Recall (PAR)

Today's date: ___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year) **Day** *(check only one)*: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun **OR Not done → Specify reason** *(use codelist below)*: ___

1 Were you employed in the last seven days? ☐0 No → **Skip to question 3** ☐1 Yes **Interviewer initials:** ___ ___ ___ (first middle last)

2 If Yes: Which days *(check all that apply)*? ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

3 Which days do you consider your weekend, or non-work, days? ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Day #	Day of Week	Date	Sleep Time		Work Time		Morning *(in minutes)*			Afternoon *(in minutes)*			Evening *(in minutes)*		
			In Bed	Up	Start	Stop	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard	Mod.	Hard	Very Hard
7 *(yesterday)*		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
6		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
5		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
4		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
3		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
2		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									
1 *(1 week ago)*		___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59) ___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)	___ ___ : ___ ___ (00:00 to 23:59)									

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Seven-Day Physical Activity Recall (PAR) (continued)

4 **Compared to your physical activity over the past three months, was last week's physical activity more, less, or about the same** *(check only one)***?**

- ☐ 1 More
- ☐ 2 Less
- ☐ 3 About the same

Interviewer: Please answer questions below and note any comments on interview.

5 **Were there any problems with the Seven-Day PAR interview?**

- ☐ 0 No
- ☐ 1 Yes

6 **Do you think this was a valid Seven-Day PAR interview?**

- ☐ 0 No
- ☐ 1 Yes

7 **Were there any activities reported by the participant that you don't know how to classify?**

- ☐ 0 No
- ☐ 1 Yes

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

6-Day Food Record

Complete below OR Not done → Specify reason *(use Codelist below)*: _____ **Staff initials:** ___ ___ ___ (first middle last)

			Replacement Values		
Day of DLW	**Date of Record**	**Record Quality** *(check only one)*	**Day of DLW**	**Date of Record**	**Record Quality** *(check only one)*
1	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	8	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing
2	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	9	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing
3	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	10	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing
4	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	11	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing
5	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	12	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing
6	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing	13	___ ___ / ___ ___ ___ / ___ ___ ___ ___ (day / month / year)	☐ 1 Reliable ☐ 2 Unreliable ☐ 3 Missing

Not Done Codelist: **1** Participant refused **2** Clinician unable to obtain **3** Insufficient time **4** Instrument failure **5** Not required

Concomitant Medications Log

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Concomitant Medications Log

Record any medications taken after start of baseline visit, including over-the-counter and prescription drugs, vitamins, supplements, and herbal medications. Update form for each visit and mark corresponding additional box.
Send copies of this form with each submission starting with baseline:

☐ Baseline 1 ☐ Baseline 2 ☐ Month 1 ☐ Month 3 ☐ Month 6 ☐ Month 9 ☐ Month 12 ☐ Month 18 ☐ Month 24

Medication	Start Date or ☑ if Pre-study	Stop Date or ☑ if Continuing	Indication
1 Study vitamin-mineral supplement	__ __/__ __ __/__ __ __ __ (day/month/year)	__ __/__ __ __/__ __ __ __ (day/month/year)	
2 Study calcium supplement	__ __/__ __ __/__ __ __ __ (day/month/year)	__ __/__ __ __/__ __ __ __ (day/month/year)	
3	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
4	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
5	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
6	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
7	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
8	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
9	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
10	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
11	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	
12	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Pre-study	__ __/__ __ __/__ __ __ __ (day/month/year) OR ☐1 Continuing	

Concomitant Medications Log

Center Number: ___ ___ Participant Number: ___ ___ ___ ___ Participant's Initials: ___ ___ ___ (first middle last)

Study Calcium Supplement 1000 mg

Medication	Start Date	Stop Date
Study calcium supplement, 1000 mg	__ __/__ __ __/__ __ __ __ (day month year)	__ __/__ __ __/__ __ __ __ (day month year)

calerie Phase 2

Completed by Calerie staff:
☐ Baseline 1 ☐ 6 Months ☐ 18 Months
☐ Baseline 2 ☐ 12 Months ☐ 24 Months

Center Number: ___ ___ **Participant Number:** ___ ___ ___ ___ **Participant's Initials:** ___ ___ ___ (first middle last)

Daily Home Weight Log

Were you issued a new scale? ☐$_0$ No ☐$_1$ Yes → **If Yes: Date first used:** ___/___/_____ (month/day/year) **Serial no.:** __________

Please complete this log in either blue or black ink.

Day of week: __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb **Check scale memory**
Day of week: __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb	**Day of week:** __________ **Date:** ___/___/_____ (month/day/year) **Time:** ☐$_1$ AM ☐$_2$ PM ___:___ (00:00 to 11:59) **Weight:** ___ ___ ___ . ___ lb **Check scale memory**

Send Completed Logs to DCRI Only If Completed During DLW Periods

Send to DCRI Forms Management • 2400 Pratt St. • Room 0311 Terrace Level • Durham NC 27705